

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN6201</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/25/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>EAST TENNESSEE HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>465 ISBILL RD MADISONVILLE, TN 37354</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments  During complaint investigation #29517, and #29635, conducted on April 23, 2012, through April 25, 2012, at East Tennessee Health Care, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6599

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If continuation sheet 1 of 1